

## INSTRUCTIONS FOR PHYSICIAN'S ASSISTANT APPLICATION FOR LICENSURE

### GENERAL INFORMATION

**NOTE: Please be advised that you are required to obtain the Board's written authorization before practicing with a new supervising physician.**

#### **APPLICATIONS WILL NOT BE REVIEWED WITHOUT APPLICATION FEE**

Application Fee: **\$200.00**; Make check/money order payable to: **Georgia Medical Board. Georgia State Government or Georgia County employees are fee exempt.** Federal government employees are not exempt.

**Please read the instructions carefully PRIOR TO attempting to answer the questions on the Physician's Assistant Application Forms. Also, please read the Frequently Asked Questions regarding Physician's Assistants on our web site at [www.medicalboard.georgia.gov](http://www.medicalboard.georgia.gov)**

#### **FALSIFICATION/MISREPRESENTATION**

Please be aware that falsification or misrepresentation of any item or response on this application or any attachment hereto is sufficient basis for denying or revoking a license.

- 1.) All applicants must have graduated from an accredited Physician's Assistant education program approved by the Board.
- 2.) All applicants must submit:
  - Completed **Physician's Assistant Application**.
  - Current **résumé** of activities and education.
  - **Affidavit of Applicant** (must be signed, dated and notarized). The applicant and notary signature dates **must match**.
  - **Application for Utilization of a Physician's Assistant** completed by the **primary** supervising physician. Supervising physician must also list all alternate supervising physicians, if applicable.
  - **Basic Job Description** signed by the applicant and the primary supervising physician.
  - Current **photograph** that is 2"x2", head and shoulders only, and not more than six months old. Attach photograph to Affidavit.
- 3.) Submit "**Certificate of Education For Physician's Assistants,**" to your school. Please ask the school to complete this form and mail directly to the Georgia Medical Board.
- 4.) Applicants must provide two (2) current **references**, addressed to the Board, and must be from licensed physicians, other than proposed employer and/or director of training program, who have supervised you. Applicants downloading application forms from our web site must download two (2) copies of the Physician's Assistant Reference Form.
- 5.) If you have ever been issued a physician's assistant license in another state, regardless of the status of your license, you must have the state licensing board(s) complete and mail the "**Verification of Licensure Form**" directly to the Georgia Medical Board. Applicants who download this form from our web site must download one form for each state in which you hold or have held a license.
- 6.) Section J of the Basic Job Description allows **prescribing privileges** for Physician's Assistants. If you do not need these privileges, the physician may cross through this section.
- 7.) The Board meets 12 times a year to consider completed applications. Your completed application must be received 15 business days prior to the next month's board meeting to be considered. Generally, the Medical Board meets the first week of the month in which there is a consecutive Thursday and Friday. (eg, if the Thursday is the 31<sup>st</sup> of a month and Friday is the 1<sup>st</sup> the board will not meet until the following week). Please check call us at (404) 656-3913 to confirm our board meeting dates or check our web site for this information.
- 8.) The license renewal deadline is December 31<sup>st</sup> of even numbered years. The renewal fee is **\$105.00**
- 9.) All forms must be returned to:

#### **COMPOSITE STATE BOARD OF MEDICAL EXAMINERS**

##### ***Physician's Assistants Licensure Unit***

- 2 Peachtree Street, N.W., 36<sup>th</sup> Floor •
- Atlanta, Georgia 30303
- Telephone: 404.656.3913
- Fax: 404.656.9723

**NOTE: You may not begin work without a license or written temporary approval from the Georgia Medical Board.**

When the application is complete, a temporary approval letter will be issued and will remain in effect until a passing score from the NCCPA or the NCCAA has been received and reviewed by the Medical Board. Temporary approval may not be issued to anyone who has failed an examination until documentation is received indicating a passing score.



**IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, YOU ARE REQUIRED TO FURNISH COMPLETE DETAILS, INCLUDE DATE, PLACE, REASON, AND DISPOSITION OF THE MATTER (INCLUDE COPIES OF COURT ORDERS OR MALPRACTICE SUITS IF APPLICABLE).**

	YES	NO	<b>GMB USE ONLY – PREVIOUSLY DECLARED</b>
7. Have you ever been treated or hospitalized for mental illness, drug or alcohol abuse during the last seven (7) years? (If you answer yes to this question, provide letter(s) from all treating physician(s) directly to the Board.)	_____	_____	_____
8. Have you ever been convicted of a violation of any National, Federal (including military) State or local Statute?	_____	_____	_____
9. Have you ever been denied the privilege of taking an examination by any State licensing board or been denied a certificate/licensure, or refused renewal of a certificate or license by any licensing board or agency?	_____	_____	_____
10. Has any state licensing board revoked or suspended a certificate issued to you or taken any other disciplinary action?	_____	_____	_____
11. Have you ever had any malpractice suits filed against you?	_____	_____	_____
12. Have you ever had your hospital privileges limited, denied or revoked?	_____	_____	_____
13. Have you ever resigned from a hospital after a complaint or for any other reason that has been initiated against you? Have you had any restrictions on Medicaid or Medicare? (If yes, please circle one.)	_____	_____	_____
14. Have you ever voluntarily surrendered your PA certificate/license?	_____	_____	_____
15. To your knowledge, are you the subject of an investigation by any licensing Board or any other agency as of the date of this application?	_____	_____	_____
16. Have you ever defaulted on a state or federally funded and/or guaranteed school loan?	_____	_____	_____
17. Have you ever defaulted on child support payments?	_____	_____	_____

18. City/Town, County, State of High School Attended and Graduation Date:

City	County	State
_____	_____	_____
High School		Graduation Date _____

19. Name and Location of College Attended and Date of Attendance/Graduation:

1. _____	From _____	To _____
School Name		
_____	Graduation Date	_____
Location		
2. _____	From _____	To _____
School Name		
_____	Graduation Date	_____
Location		

## 20. AFFIDAVIT OF APPLICANT

I acknowledge and state that I have read and am familiar with the Physician's Assistant Act and rules pertaining thereto. I further state that by filing this application for licensure as physician's assistant in the State of Georgia; I authorize and consent to have an investigation made as to my moral character, professional reputation and fitness to practice as a P.A. I agree to give any further information, which may be required in reference to my past record. I understand that I will not receive a copy of the report or know its content and I further understand that the contents of the investigative report will be privileged unless determined otherwise by the Board or Court Order.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state Federal or foreign) court, association, institution or any other organization having control of any documents, records or other such information pertaining to me, to furnish to the Composite State Board of Medical Examiners any such documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and permit the Georgia Composite State Board of Medical Examiners or any of its agents or representatives to inspect and make copies of such documents, records or other information, in connection with this application, subsequent to practice thereunder.

I hereby release, discharge, and exonerate the Georgia Composite State Board of Medical Examiners for any and all liability of every nature and kind arising out of the furnishing or inspections of such documents, records or other information or any investigation made by the Georgia Composite State Board of Medical Examiners to release information, material, documents, orders or the like relating to me or to this application to any other agency or any other agency of the State of Georgia, the medical licensing agency of any other state or territory of the United States, or Province of Canada, the Federation of State Medical Boards, or the U.S. Inc. law enforcement agency, hospital or other appropriate agencies as determined by the Board.

This is to certify that the foregoing information is true and correct to the best of my knowledge. I understand that pursuant to the Official Code of Georgia Annotated. Section 43-43-46 and 43-1-19(a)(2), any person who shall give false or forged evidence of any kind to the Board in connection with an application, shall be guilty of a felony and upon conviction thereof, shall be punished by paying a fine or not less than \$500.00 nor more than \$1,000.00 or by imprisonment from two to five years or both. False swearing may constitute a felony offense under O.C.G.A. § 16-10-71. I understand that working with a Physician's Assistant license and falsely presenting myself to the public as a licensed physician is a violation of the Physician's Assistant Act and the Rules of the *Composite State Board of Medical Examiners*.

\_\_\_\_\_  
Signature of Applicant                      Date

County \_\_\_\_\_ State \_\_\_\_\_

\_\_\_\_\_  
Name of Applicant

\_\_\_\_\_  
City and State

Photo 2" x 2"  
Head & Shoulders

Being duly sworn and says, that he/she is the person who executed the above application; and that all statements herein contained are true and that the attached photograph is a true likeness of the applicant not more than six (6) months prior to the application date.

Sworn and subscribed before me this \_\_\_\_\_

Day of \_\_\_\_\_, \_\_\_\_\_.

Notary Public \_\_\_\_\_

SEAL

# COMPOSITE STATE BOARD OF MEDICAL EXAMINERS



EXECUTIVE DIRECTOR  
LaSharn Hughes, MBA

MEDICAL DIRECTOR  
Jim H. McNatt, MD

2 Peachtree Street, N.W., 36<sup>th</sup> Floor • Atlanta, Georgia 30303 • Tel: 404.656.3913 • <http://www.medicalboard.georgia.gov>  
E-Mail: [Medbd@dch.state.ga.us](mailto:Medbd@dch.state.ga.us)

## 21. CERTIFICATE OF EDUCATION FOR PHYSICIAN'S ASSISTANT

It is hereby certified that \_\_\_\_\_  
(student's Name)

of \_\_\_\_\_ matriculated in \_\_\_\_\_  
(City, State of Birth)

at \_\_\_\_\_ on \_\_\_\_\_.

The dates of attendance are certified to be: from \_\_\_\_\_ to \_\_\_\_\_.  
The above named applicant completed PA/AA studies from

\_\_\_\_\_ on \_\_\_\_\_ and was

granted a \_\_\_\_\_ degree or certificate (please circle one).

\_\_\_\_\_  
Signature of Dean, Registrar or Director (please circle one)

(SCHOOL SEAL)

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Notary Public

Sworn to and subscribed before me

This \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

My commission expires \_\_\_\_\_, 20 \_\_\_\_\_.

**Special Note: This form must be either notarized or have the school seal embossed or attached. Please mail the completed form to the address listed on the top of this form.**

# COMPOSITE STATE BOARD OF MEDICAL EXAMINERS

## APPLICATION FOR UTILIZATION OF PHYSICIANS ASSISTANT

1. PHYSICIAN NAME: \_\_\_\_\_  
(First) (Middle ) (Last) ( Degree)

2. BUSINESS ADDRESS: \_\_\_\_\_  
(Street Address) (Business Telephone)  
\_\_\_\_\_  
(City) (State) (Zip Code)

3. RESIDENCE ADDRESS: \_\_\_\_\_  
(Street Address)  
\_\_\_\_\_  
(City) (State) (Zip Code)

4. PHYSICIAN SPECIALTY \_\_\_\_\_ GEORGIA LICENSE NUMBER \_\_\_\_\_

5. LIST CURRENT BOARD CERTIFICATIONS: \_\_\_\_\_  
\_\_\_\_\_

6. NAME OF PROPOSED PHYSICIAN'S ASSISTANT & CURRENT ADDRESS:

Name: \_\_\_\_\_ DEA No.: \_\_\_\_\_  
(First) (Middle ) (Last)

Address: \_\_\_\_\_  
(Street Address)  
\_\_\_\_\_  
(City) (State) (Zip Code)

7. Type of Practice and Proposed Setting:

\_\_\_\_\_  
\_\_\_\_\_

8. ALTERNATE SUPERVISING PHYSICIANS: Only the primary supervising physician may designate alternate supervisors for his/her PA. When the supervisory relationship between the primary supervising physician and the PA ends, the relationship with the alternate supervising physicians listed below ends as well. All signatures must be original. Signature stamps and photocopies are not acceptable.

Physicians Printed Name	License No.	Physician's Signature
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____